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Selling patients and other metaphors: A discourse analysis of the interpretive frames that shape emergency department admission handoffs

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ABSTRACT

This paper reports a discourse analysis of the language doctors used as they talked about and engaged in patient handoffs between the emergency department (ED) and various inpatient services at one highly specialized academic tertiary teaching and referral hospital in the Midwest United States. Although interest in handoff improvement has grown considerably in recent years, progress has been hampered, perhaps in part, because of a widely used but limiting conceptual model of handoff as an information transmission. The purpose of the study reported here is to analyze the way doctors make sense of handoff interactions, including uncovering the interpretive frames they use, in order to provide empirical findings to expand conceptual models of handoff. All data reported were drawn from a two-year ethnographic study (2009–2011) and include semi-structured interviews (n = 48), non-participant observations (349 h), and recorded telephone handoff conversations (n = 48). A total of eighty-six individuals participated, including resident and attending doctors from the ED, internal medicine and surgical services, as well as hospital administrators. Findings are organized around four metaphors doctors used: sales, sports and games, packaging, and teamwork. Each metaphor, in turn, reveals an underlying interpretive frame that appears to be influenced by organizational and social structures and to shape the possibilities for action that doctors perceive. The four underlying interpretive frames are: handoff as persuasion, handoff as competition, handoff as expectation matching, and handoff as collaboration. Taken together, these interpretive frames highlight the complex, socially interactive nature of handoff and provide an empirical basis for grounding and enriching the conceptual model of handoff that guides research and practice improvement efforts.

Introduction

In this paper I draw from a two-year ethnographic study of admissions work at one US academic tertiary hospital to examine the interpretive frames that doctors use to make sense of the handoffs that occur when patients are admitted from the emergency department (ED) to various inpatient services. Handoffs are coordination routines meant to bridge the discontinuities of care that occur when responsibility for a patient is transferred between providers. Handoffs are important because current practices are thought to be inadequate (Borowitz, Waggoner-Fountain, Bass, & Sledd, 2008; Nagpal, Vats, Ahmed, Vincent, & Moorthy, 2010; Raptis, Fernandes, Chua, & Boulos, 2009), and transitions of care are believed to threaten quality and safety (Beach, Croskerry, & Shapiro, 2003; Horwitz et al., 2009; Jagsi et al., 2005). Progress on handoff improvement, however, has been slow (Cohen & Hilligoss, 2010; Ong & Coiera, 2011; Patterson & Wears, 2010), perhaps in part because of a widely used but limiting conceptual model of handoff as information transmission (Cohen, Hilligoss, & Amaral, 2012; Patterson & Wears, 2010). While all handoffs necessarily entail the exchange of information, this model overlooks the influence of social and organizational factors. By examining the interpretive frames that doctors use in relation to handoffs, my aim is to enrich our conceptual understanding of handoff and to open up new avenues for improvement.

Handoffs

Given the often-fragmented nature of health care (Bodenheimer, 2008), efforts to better integrate systems and to improve coordination activities have received increased attention

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in recent years (Epping-Jordan, Pruitt, Bengoa, & Wagner, 2004). Among such activities is the patient handoff, a crucial coordination routine in which information about and responsibility for a patient is exchanged between health providers either at shift change or when moving a patient from one unit or institution to another (Cohen & Hilligoss, 2010).

Of interest here are admission handoffs between ED physicians and their counterparts on various inpatient services. Among the challenges associated with such handoffs are two that figure in the findings I report below. First, there are frequently uncertainties surrounding patients who pass through emergency departments (Apker, Mallak, & Gibson, 2007; Behara et al., 2005; Nugus & Braithwaite, 2010). Such patients are often highly vulnerable, at early stages of acute illness episode when it can be difficult to know the cause of their complaints or the likely future course of their illnesses. Consequently, doctors sometimes disagree over decisions to admit patients or to place them on particular services (Eisenberg et al., 2005; Hilligoss & Cohen, 2013; Nugus, Bridges, & Braithwaite, 2009; Nugus et al., 2010). Additional ambiguities can emerge as a result of pending lab and test results at the time of handoff and the practice of boarding—physically keeping a patient in the ED after handoff, awaiting an available bed (Apker et al., 2007).

Second, because they cross organizational boundaries, admission handoffs are challenged by the fact that involved parties usually have differing professional orientations and perspectives (Abraham & Reddy, 2010; Apker et al., 2007; Horwitz et al., 2009; Nugus et al., 2010). ED physicians tend to be focused on urgent conditions and efforts to stabilize and disposition patients. Internal medicine physicians, on the other hand, tend to be focused on diagnosing the underlying causes of disease and on longer-term treatment efforts. Sub-specialty internal medicine physicians are focused on single organs or systems, while ED and general internal medicine doctors attend to the whole body (Nugus et al., 2009). These differences are exacerbated by differences in terminology (Nugus et al., 2009) and communication practices (Apker et al., 2007), and stereotyping (Horwitz et al., 2009).

Reviews of the handoff literature (Hilligoss & Cohen, 2011; Ong & Coiera, 2011; Riesenberg, Leisch, & Cunningham, 2010) indicate considerable attention has been directed toward handoffs but has not led to clear best practices or reliable measurements (Cohen & Hilligoss, 2010; Ong & Coiera, 2011; Patterson & Wears, 2010). In part, this lack of progress may stem from a fundamentally limited conceptual model of handoff as an information transmission activity (Cohen et al., 2012; Patterson & Wears, 2010) and a related lack of field research aimed at understanding handoffs in context (Wears, 2012). By starting from the assumption that handoffs are faulty information transmissions in which a sender fails to deliver a message accurately and completely to a receiver, the field has rushed to "fix" information transmission without first developing a rich, contextually-sensitive understanding of the social dynamics of handoffs.

Some research does offer evidence that the information transmission model does not fully capture the complexity of the activity. In their ethnographic study of doctors in two Australian hospitals, Nugus et al. (2009) found that ED physicians had to "sell"—that is, communicate persuasively—admissions to their counterparts on various inpatient services. Similarly, a study of psychiatric assessment referrals on a toxicology ward of a UK hospital also found that artful negotiation tactics were important to the successful transfer of patients (Hartswood, Procter, Rouncefield, & Slack, 2003). These studies from two different continents and very different settings, combined with observations by others (e.g., Apker et al., 2007; Beach et al., 2012; Eisenberg et al., 2005; Horwitz et al., 2009), suggest that persuasion and negotiation, although rarely acknowledged, may play a regular role in accomplishing transitions of care between settings. Given this possibility, we need a richer understanding of the interpretive frames that doctors use in relation to handoff and which shape their perceptions of constraints and enablers of action. This understanding will contribute to the enrichment of the conceptual models used in handoff research, grounding them in empirical data.

Interpretive frames

How people make sense of the situations in which they find themselves shapes the possibilities for action they perceive, the consequences of actions they anticipate, and the motives they impute to others (Berger & Luckmann, 1966; Weick, 1979, 1995). In this paper, I use the term *interpretive frame* to refer to the conceptual lens through which an actor makes sense of a situation or experience. Throughout sociology, psychology, and other disciplines, a variety of related terms refer, more or less, to the same general idea: for example, interpretive scheme (Bartunek, 1984; Giddens, 1984; Ranson, Hinings, & Greenwood, 1980; Schütz, 1932/1972), schema (Poole, Gioia, & Gray, 1989), framing (Goffman, 1974; Tversky & Kahneman, 1981), cognitive map (Tolman, 1948), and script (Gioia & Poole, 1984). There are, of course, important distinctions among these concepts. For example, some focus on individual psychological processes (Tolman, 1948; Tversky & Kahneman, 1981), while others focus on the influences of collectivities (Schütz, 1932/1972). Some emphasize situational factors (Goffman, 1974; Weick, 1995), while others emphasize enduring structures (Berger & Luckmann, 1966; Foucault, 1972; Ranson et al., 1980). What all of these concepts acknowledge is that our perceptions, interpretations, and insights are both enabled and constrained by the interpretive frame through which we experience an event. To be clear, interpretive frames "set the stage" for behaviors; they do not determine them (Gioia & Poole, 1984).

One approach to identifying and analyzing interpretive frames involves discourse analysis (Alvesson & Karreman, 2000; Gee, 2005). Patterns in the words and phrases actors use as they describe or act in situations can provide insights into the sense they make of those situations. Approaches to discourse analysis are multiple and varied, ranging from micro to meso to macro (Alvesson & Karreman, 2000). At the one extreme (micro), the focus is on the situated use of language to enact identities and accomplish actions (e.g., Goffman, 1974). At the other extreme (macro), the focus is on long-term, socially standardized ways of referencing phenomena, such as systems of thought or knowledge (e.g., Foucault, 1972). A meso discourse approach (Alvesson & Karreman, 2000; Mitchell, 2009), which I use here, involves analysis of language use in context with the goal of identifying systematic patterns of discourse that are shared collectively. At the heart of all discourse analyses is the fundamental argument that discourses not only describe but also accomplish things (Potter & Wetherell, 1987).

Attending to metaphorical language can be particularly advantageous (Grant & Oswick, 1996; Lakoff & Johnson, 1980; Morgan, 1997). Metaphorical thinking is central to science (Miller, 1986) and theory development (Grant & Oswick, 1996; Morgan, 1997; Weick, 1989), but more broadly, metaphors infuse everyday language (Lakoff & Johnson, 1980) and shape how we think about topics from the mundane to the profound. Our ability to understand new experiences and domains often involves translating them into others that are more familiar, and our comprehension of abstract ideas frequently hinges on mapping them onto more concrete ones (Lakoff, 1987). For example, when we talk about "saving" or "wasting" time, we are engaging a metaphor that transfers actions associated with concrete, material goods, such as currency, onto the more abstract notion of temporality. By overlaying meaning from